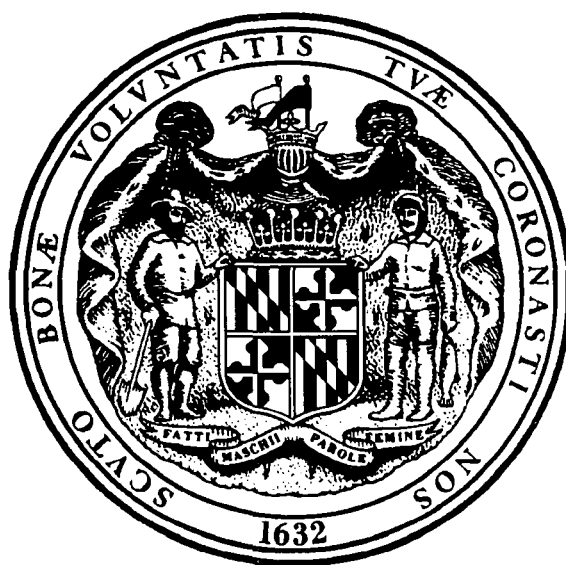


971835

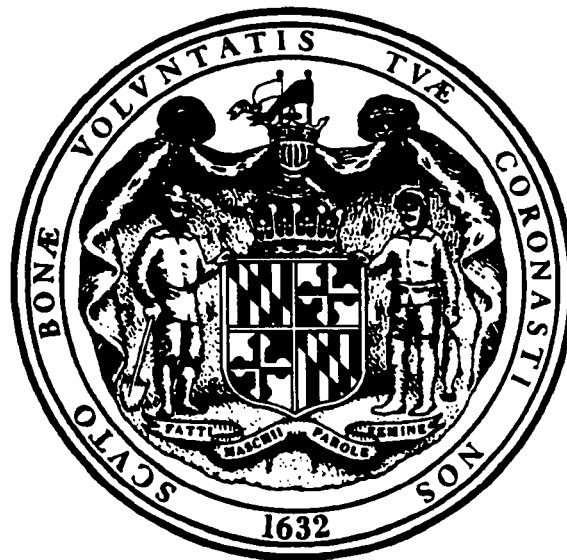
**REPORT OF THE  
TASK FORCE TO STUDY  
PATIENT AND PROVIDER  
APPEAL AND GRIEVANCE MECHANISMS**



**ANNAPOLIS, MARYLAND**

**December 1996**

**REPORT OF THE  
TASK FORCE TO STUDY  
PATIENT AND PROVIDER  
APPEAL AND GRIEVANCE MECHANISMS**



**ANNAPOLIS, MARYLAND**

**December 1996**

*For information regarding content  
or for copies of this publication, contact:*

*Department of Legislative Reference  
90 State Circle  
Annapolis, Maryland 21401*

Baltimore Area: 410-841-3870  
Washington Area: 301-858-3870  
Other Areas: 1-800-492-7122  
TTY: 410-841/301-858-3814

The Department of Legislative Reference does not discriminate on the basis of race, color, national origin, sex, religion, or disability in the admission or access to its programs or activities. Sherry M. Little, the Department's Information Officer, has been designated to coordinate compliance with the nondiscrimination requirements contained in section 35.107 of the Department of Justice Regulations. Requests for assistance should be directed to Ms. Little at the Library and Information Services Division of the Department of Legislative Reference at the Above address.



GENERAL ASSEMBLY OF MARYLAND  
ANNAPOLIS, MARYLAND 21401

December 1, 1996

Honorable Thomas L. Bromwell, Chairman, Senate Finance Committee  
Honorable Michael E. Busch, Chairman, House Economic Matters Committee

The Task Force to Study Patient and Provider Appeal and Grievance Mechanisms respectfully submits its report summarizing the Task Force's findings and recommendations. The Task Force met four times during the 1996 interim generating the materials for this report.

Managed care controls costs through capitation, discounted payments to providers, and financial incentives intended to enhance quality and minimize unnecessary utilization. However, as some parties raise concerns that financial incentives diminish health care quality, there has been an increasing focus on the evaluation of grievance and complaint procedures, and determination of due process rights for enrollees and providers within the managed care system. To that end, the Task Force made a number of findings about regulatory oversight in Maryland and the role of informal mediation. The Maryland Association of Health Maintenance Organizations and the Health Care Provider Coalition submitted proposals to the Task Force.

The Task Force recommends that it continue its inquiry into the issue of provider and patient appeal and grievance mechanisms to: (1) monitor implementation of the MIA's computer system with its ability to track and report on complaints about HMOs, and the data that the system ultimately provides; (2) evaluate regulations regarding grievance procedures and access to an ombudsman for Medical Assistance recipients adopted in accordance with Chapter 352 of the Acts of the General Assembly of 1996; (3) clarify the role of "medical necessity" in resolving grievances and appeals over access to services; and (4) monitor any relevant legislation introduced during the 1997 Legislative Session.

Respectfully submitted,

Larry Young, Senate Chairman

John P. Donoghue, House Chairman



**Maryland General Assembly  
Task Force to Study Patient and Provider Appeal and Grievance Mechanisms**

**Membership Roster**

---

**Senator Larry Young, Senate Chairman  
Delegate John P. Donoghue, House Chairman**

**Senators**

Martin G. Madden  
John C. Astle

**Delegates**

Marilyn Goldwater  
Peter A. Hammen

**Representatives of the Medical and Chirurgical Faculty of Maryland**

James R. Christina, D.P.M.  
Willarda V. Edwards, M.D.  
Burt Allan Littman, M.D.

**Representatives of Maryland health maintenance organizations**

Eric R. Baugh, M.D.  
Elmira C. Gwynn  
R. Lane Wroth, M.D.

**Task Force Staff**

Enrique Martinez-Vidal, Legislative Analyst, Dept. of Legislative Reference  
Donna Imhoff, Legislative Counsel, Dept. of Legislative Reference



## **Report of the Task Force to Study Patient and Provider Appeal and Grievance Mechanisms**

As managed care gains an increasing proportion of the health care delivery system, concerns have surfaced about the interrelationships among participants in the system, and the ability of patients and providers to contest decisions rendered by managed care plans. Accordingly, the General Assembly commissioned a Task Force to evaluate the use and effectiveness of patient and provider grievance and appeal mechanisms that, by law, must be adopted by health maintenance organizations that operate in Maryland.

The Task Force to Study Patient and Provider Appeal and Grievance Mechanisms was established under Chapter 548 of the Acts of the General Assembly of 1996 (Appendix 1). Members of the Task Force were Senators Larry Young, Martin G. Madden, and John C. Astle; Delegates John P. Donoghue, Marilyn Goldwater, and Peter A. Hammen; three representatives of the Medical and Chirurgical Faculty of Maryland: James R. Christina, D.P.M., Willarda V. Edwards, M.D., and Burt Allan Littman, M.D.; and three representatives of Maryland health maintenance organizations (HMOs): Eric R. Baugh, M.D., Elmira C. Gwynn, and R. Lane Wroth, M.D. Senator Young and Delegate Donoghue chaired the Task Force.

The Task Force held briefings on October 1, October 22, and October 29, 1996 (see Appendix 2 for minutes). On November 12, 1996, it met for a work session. The Task Force sent a letter to the Legislative Policy Committee and the Chairmen of the Senate Finance and House Economic Matters Committees requesting an extension be given to submit its report (Appendix 3).

### **Findings of the Task Force**

Managed care controls costs through capitation, discounted payments to providers, and financial incentives intended to enhance quality and minimize unnecessary utilization. However, as some parties raise concerns that financial incentives diminish health care quality, there has been an increasing focus on the evaluation of grievance and complaint procedures, and determination of due process rights for enrollees and providers within the managed care system. To that end, the Task Force made the following findings.

#### **I. Regulatory Oversight**

##### **1. Maryland Insurance Administration (MIA)**

The Life and Health Inquiry and Investigation Unit receives and investigates complaints and requests for information about policy contracts and other insurance problems and questions.

The Unit investigates complaints about premium problems, claims handling, coordination of benefits, and agent misrepresentations for various types of health insurance including HMOs, long term care, and dental care.



Multiple complaints about a particular entity trigger an initiation of a market conduct examination for that entity.

The MIA computer system cannot distinguish between complaints and inquiries.

The computer system cannot determine who initiated a complaint or produce computer reports about complaint resolution.

The MIA has formed an internal Complaint Committee to review and improve the complaint process (Appendix 4). Part of the Committee's charge is to design a relational data base that will log all complaints in a manner that will allow the MIA to extract relevant information on the number and types of complaints received.

## **2. Department of Health and Mental Hygiene: Office of Licensing and Certification**

The Office of Licensing and Certification monitors the quality of care and compliance with both State and federal regulations in health-care facilities and health-related services and programs. This includes any complaints about health maintenance organizations in the area of "quality of care."

In 1996, the Office received 16 complaints about HMOs (eight concerning "access to services"; six on "quality of care" issues; and two on "benefit coverage" issues) (Appendix 5).

An evaluation of each licensed HMO occurs at least every two years and includes a review of the grievance process.

An HMO is required by law to give the DHMH complaint phone number to its enrollees.

DHMH regulations require annual reports on grievance procedures and proceedings. HMOs do not submit the reports and no penalties have been imposed.

The Office reviews HMOs as Private Review Agents (PRA). The review includes an examination of the PRA grievance process.

## **3. Department of Health and Mental Hygiene: Medical Care Finance and Compliance Administration**

The Medical Care Finance and Compliance Administration is responsible for a Medicaid recipient's right to appeal. The final appeal is to the Office of Administrative Hearings.

The Administration annually receives about 6000 calls to the complaint hotline of which approximately 150, or 2.5 percent, are complaints about HMOs.

A Medicaid recipient who is dissatisfied can disenroll from the HMO.

Regulations adopted in accordance with Chapter 352 of the Acts of the General Assembly of 1996 establish an ombudsman and a specific grievance process for Medicaid enrollees.

## **II. Informal Mediation:**

### **Division of Consumer Protection of the Office of the Attorney General.**

The Health Education and Advocacy Unit of the Division of Consumer Protection mediates consumer complaints regarding billing and reimbursement issues and access to services.

Although the Unit cannot order a particular remedy, it estimates an 80-85 percent success rate in arriving at a satisfactory result for the consumer.

The Office received approximately 75 to 80 complaints against HMOs in the past twelve months. Of the 800 to 1,000 complaints the Health Advocate receives each year, complaints related to HMOs account for about 10 percent.

## **III. Health Maintenance Organizations**

The Maryland Association of Health Maintenance Organizations (MAHMO) proposes that no documentation presented to the Task Force supports the supposition that the current system of appeals and grievances for patients and providers is not working.

In a statement presented to the Task Force (Appendix 6), MAHMO made the following recommendations to the Task Force:

- The MIA should be the single point of entry for all appeals and complaints regarding HMOs, and
- No legislative action is required for the 1997 Session concerning the issue of HMO appeal mechanisms.

## **IV. The Health Care Provider Coalition**

The Health Care Provider Coalition proposes that there are a number of problems concerning patient and provider complaints and appeals concerning medical insurance coverage, and determinations of medical necessity.

The Coalition submitted a proposal to the Task Force for an appeal and grievance procedure for patient and provider complaints (Appendix 7).

## **Recommendations of the Task Force**

The Task Force recommends that it continue its inquiry into the issue of provider and patient appeal and grievance mechanisms to:

- Monitor implementation of the MIA's computer system with its ability to track and report on complaints about HMOs, and the data that the system ultimately provides;
- Evaluate regulations regarding grievance procedures and access to an ombudsman for Medical Assistance recipients adopted in accordance with Chapter 352 of the Acts of the General Assembly of 1996;
- Clarify the role of "medical necessity" in resolving grievances and appeals over access to services; and
- Monitor any relevant legislation introduced during the 1997 Legislative Session.

## APPENDIX 1

6

### HOUSE BILL 1374

1

#### Chapter 577 of the Acts of 1995

2       SECTION 2. AND BE IT FURTHER ENACTED, That the Insurance  
3 Commissioner, when developing [the uniform provider voucher form] the uniform  
4 laboratory referral form[,] and the uniform consultation referral form under Article  
5 48A, § 490BB of the Code, shall consult with the Department of Health and Mental  
6 Hygiene, the Health Care Access and Cost Commission, the Office on Aging, Blue Cross  
7 and Blue Shield of Maryland, Blue Cross and Blue Shield of the National Capital Area,  
8 the Health Insurance Association of America, the League of Life and Health Insurers,  
9 the Maryland Hospital Association, the Medical and Chirurgical Faculty of Maryland, the  
10 Medical Group Management Association, a representative of the medical laboratory  
11 industry in the State; the Maryland Association of Health Maintenance Organizations,  
12 and a nonphysician health care provider association. The forms developed under this  
13 section shall be capable of electronic transfer.

14       SECTION 3. AND BE IT FURTHER ENACTED, That the Insurance  
15 Commissioner, when developing the forms in accordance with the requirements of  
16 Section 2 of this Act, shall assess any existing uniformity of forms currently being used  
17 within the health care delivery and finance industries, and shall examine any uniformity of  
18 forms that may be required in other states. IN ADDITION TO THE REQUIREMENTS OF  
19 SECTION 2 OF THIS ACT, THE INSURANCE COMMISSIONER, IN CONSULTATION WITH  
20 THE REPRESENTATIVES OF THE AGENCIES, ASSOCIATIONS, AND ORGANIZATIONS  
21 DESCRIBED UNDER SECTION 2 OF THIS ACT, SHALL STUDY THE FEASIBILITY OF A  
22 UNIFORM VOUCHER FORM FOR HEALTH CARE PROVIDERS.

23       SECTION 2. AND BE IT FURTHER ENACTED, That:

24           (a) There is a Task Force to Study Patient and Provider Appeal and  
25 Grievance Mechanisms;

26           (b) The Task Force shall consist of the following members:

27               (1) Three representatives of the Medical and Chirurgical Faculty of  
28 Maryland, of whom one shall be a nonphysician licensed health care provider, appointed  
29 by the Governor;

30               (2) Three representatives of Maryland health maintenance  
31 organizations, appointed by the Governor;

32               ~~(3) Two representatives of Maryland hospitals, appointed by the~~  
33 ~~Governor;~~

34               ~~(3)~~ ~~(4)~~ ~~(3)~~ Three members of the House ~~Economic Matters~~  
35 ~~Committee of Delegates~~, appointed by the Speaker of the Maryland House of Delegates;  
36 and

37               ~~(4)~~ ~~(5)~~ ~~(4)~~ Three members of the Senate Finance Committee,  
38 appointed by the President of the Senate of Maryland;

39           (c) From among the members of the Task Force, the Governor shall  
40 designate a Chairman of the Task Force;

41           (d) The members of the Task Force shall serve without compensation;

1 (e) The Task Force shall:

2 (1) Evaluate the use and effectiveness of patient and provider  
3 grievance and appeal mechanisms currently in law that are used to appeal decisions of  
4 health maintenance organizations; and

5 (2) Based on the evaluation conducted, make recommendations  
6 concerning:

7 (i) The use and effectiveness of these appeal mechanisms; and

8 (ii) The need for legislative action; and

9 (f) On or before October 15, 1996, the House Chairman of the Task Force  
10 shall report the recommendations of the Task Force to the House Economic Matters  
11 Committee and the Senate Chairman of the Task Force shall report the recommendations  
12 of the Task Force to the Senate Finance Committee.

13 SECTION 3. AND BE IT FURTHER ENACTED, That Section 2 of this Act shall  
14 take effect June 1, 1996.

15 SECTION 4. AND BE IT FURTHER ENACTED, That Section 1 of this Act shall  
16 take effect October 1, 1996.

Approved:

\_\_\_\_\_  
Governor.

\_\_\_\_\_  
Speaker of the House of Delegates.

\_\_\_\_\_  
President of the Senate.

## APPENDIX 2



GENERAL ASSEMBLY OF MARYLAND  
ANNAPOLIS, MARYLAND 21401

### **The Task Force to Study Patient and Provider Appeal and Grievance Mechanisms**

**Tuesday, October 1, 1996**

Task Force members present: Delegates Donoghue, Goldwater, and Hammen; Senator Young; a representative of Senator Madden; Eric R. Baugh, M.D.; James R. Christina, D.P.M.; Willarda V. Edwards, M.D.; Elmira C. Gwynn; Burt Allan Littman, M.D.; and R. Lane Wroth, M.D.

#### **Item I**

The Task Force approved the drafting of a letter to be sent to the Legislative Policy Committee and the Chairmen of the Senate Finance and House Economic Matters Committees requesting an extension be given to submit the Task Force's report until November 15.

#### **Item II**

The Maryland Insurance Administration (MIA) and the Department of Health and Mental Hygiene (DHMH) briefed the Task Force on their ongoing activities concerning their respective complaint systems. The MIA noted that its computer system is outdated and that it has formed an internal Complaint Committee to review and improve the complaint process. Currently the MIA's computer system cannot distinguish between complaints and inquiries. It also cannot determine who initiated the complaint nor can it produce computer reports about complaint resolution. The MIA also briefed the Task Force on its timeline for handling complaints and its market conduct examination process. DHMH's Office of Licensing and Certification reported that in 1996, it received only 16 complaints about HMOs (eight concerning "access to services"; six on "quality of care" issues; and two on "benefit coverage" issues).

### **Item III**

Ms. Beverly J. David, Director of Patient Access and Managed Care Contracting at the Washington County Hospital Association, briefed the Task Force on some of the hospital's concerns. These concerns included:

- (1) EVS (DHMH's Eligibility Verification System) versus Medicaid HMO verification;
- (2) technical denials after emergency admission;
- (3) retrospective denials; and
- (4) appeals.

Ms. David described a series of events under the "appeals" issue as follows: (1) the HMO arrives to review members in the hospital; (2) HMO tells (hospital) Utilization Review that patient does not meet criteria for continued stay; (3) HMO will not talk to physician to discuss plan of care; (4) under the contract with the HMO, the provider is not allowed to inform patient that patient does not meet criteria and will be held financially responsible; (5) this notification is considered the first level of appeal and physician has 24 hours to respond; and (6) when HMO is questioned about when this appeals process went into effect, provider is informed that it has always been in the provider contract and is being implemented as of that day. Two aspects of the appeal were at issue: (1) the timeframe for the appeals process was implemented with no forewarning contrary to the HMO's standard of practice; and (2) the HMO is sending nurses as utilization review agents to the hospital to issue the denial of care which is being considered the first level of appeal. Ms. David noted that this problem had occurred with only one HMO.

Ms. Davis also provided the Task Force with a number of recommendations, including:

- (1) insurers should provide manuals with clear defined policies regarding denials, appeals, and grievances;
- (2) insurers should provide adequate notice of changes in policies to allow providers time to change processes;
- (3) standardized time limits for responses to appeals or grievances and outcome tracking;
- (4) require systems (automated or otherwise) to record and update membership eligibility;
- (5) develop an ombudsman (independent agency set up by the State) to help patients and providers with problem resolution; and
- (6) develop an impartial mechanism of final appeal outside of the HMO.

### **Item IV**

A panel representing providers, Jay Schwartz, Robin Shaivitz, and Dan Doherty, briefed the Task Force. They focused on the need for a patient and provider to have one place to go within state government for complaints/grievances about coverage and quality of care. It was expressed that too much falls outside of the existing system. There is also not enough accountability for deadlines. One

panelist noted that there is no uniformity in HMO appeals processes. A statement was made that the same person who first denies a treatment/procedure is the one to whom an appeal is made. The panel asserted that the Insurance Administration does not render decisions about medical necessity but it is not being done at DHMH either. They also called for increased enforcement procedures.

#### **Item V**

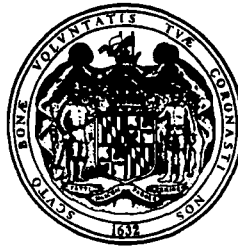
A panel representing health maintenance organizations briefed the Task Force. It consisted of Linda B. Huff (Total Health Care), Darius Rastegar (Total Health Care), Mary Stevens (Chesapeake), Robert Enten (MAHMO), and Fran Tracy (BCBSM). Their main contention was that Maryland has a fairly extensive regulatory and statutory framework for patient appeals. Provider appeals are not quite as extensive but still pretty good. They noted that member booklets tell the enrollee what to do if unsatisfied. HMOs are trying to make their members happy because employers will drop the HMO due to extensive competition. There is also competition for providers. They did not think that there is a problem with internal appeals processes and noted that most of the complaints aired were about the regulatory agencies and not the internal HMO processes. Mary Stevens reviewed some handouts that outlined Chesapeake's internal grievance and appeals processes for both patients and providers.

#### **Item VI**

The Task Force planned the next meeting for October 22, 1996 at 1:00 p.m. (Note: time was changed due to schedule conflicts). The agenda for the subsequent meeting would include: (1) single point of entry for complaints including the need for an ombudsman; (2) timely notification to providers of new or changed Utilization Review policies and procedures; (3) utilization management guidelines; and (4) retrospective denial of reimbursement.

The Task Force also requested representatives from DHMH's Office of Licensing and Certification and its Medicaid Office to be present to answer additional questions.





GENERAL ASSEMBLY OF MARYLAND  
ANNAPOLIS, MARYLAND 21401

## **The Task Force to Study Patient and Provider Appeal and Grievance Mechanisms**

**Tuesday, October 22, 1996**

Task Force members present: Delegates Donoghue, Goldwater, and Hammen; Senators Young, Madden, and Astle; Eric R. Baugh, M.D.; James R. Christina, D.P.M.; Willarda V. Edwards, M.D.; Elmira C. Gwynn; Burt Allan Littman, M.D.; and R. Lane Wroth, M.D.

### **Item I**

Larry Triplett, Director of DHMH's Medical Care Finance and Compliance Administration, briefed the Task Force on a Medicaid recipient's right to appeal. The final appeal is to the Office of Administrative Hearings.

Carol Benner, Director of DHMH's Licensing and Certification Administration, explained that her office monitors an HMO at least every two years, including its grievance process. An HMO is required to give the DHMH complaint phone number to its enrollees. Her office also reviews HMOs as Private Review Agents (PRA), who must be certified. A PRA must submit the criteria being used. The Licensing and Certification Administration looks at the criteria to see if it is sufficient and detailed enough but does not "approve." According to statute, this PRA criteria must be provided upon request. Ms. Benner noted that the problem with the PRA provision is that it is often a huge document and there are issues of the possibility that it is proprietary information.

Mr. Triplett noted that of about 6000 calls to the complaint hotline (which also gets questions), about 150 were complaints about HMOs (approximately 2.5 percent).

Delegate Goldwater asked "who has the authority to make decisions on 'medical necessity'?" Ms. Benner felt that there was no state authority to mediate between a PRA and a patient nor between a PRA and a provider.

Ms. Benner felt that, although an HMO, according to DHMH regulations, is supposed to be submitting a report on its complaints, it is better to use the survey process to examine the HMO's

complaint log, grievance process, and complaint process. Ms. Benner felt that HMOs have strong quality assurance processes.

Senator Young asked Ms. Benner, Mr. Triplett, and the MIA to each prepare a half-dozen case studies of complaints that each office receives about HMOs.

## **Item II**

Dr. Littman expressed concern with the appropriateness of PRA guidelines and the need for some way to evaluate denials by someone with objective views (i.e., a panel of experts). Dr. Baugh noted that PRA criteria are usually nationally recognized with peer review and physician input. The guidelines are constantly being reviewed and revised.

## **Item III**

A panel representing HMOs, including Bob Enten (MAHMO), Beth Sammis (MAMSI), Fran Tracy (BCBSM), and Linda Huff (THC), began to address the Task Force on the four points included on the agenda:

### **a) Single point of entry for complaints.**

The HMOs agreed that it might not be a bad idea to have a single point of entry for complaints especially if it would help the investigation and resolution of complaints. They suggested that the MIA would be the more appropriate point of entry and it has the authority to take punitive action. If the complaint was not in the purview of the MIA, it could have the ability to send the complaint to the appropriate place to be resolved but would still be responsible for following up.

The panel noted that many HMOs have consumer advocates on their appeals boards who act as advocates for the patient. Ms. Tracy suggested that maybe these appeals boards could be made more consumer friendly or have more consumer representation. Delegate Goldwater expressed the belief that consumer representatives are intimidated by the medical people on the appeals boards. The HMO panel also noted that some HMO appeals boards have disinterested providers on them.

The panel reminded the Task Force that a bill dealing with the issue of an ombudsman (SB 355) was given an unfavorable report by the Senate Finance Committee during the 1996 Session.

### **b) Timely notification to providers of new or changed Utilization Review policies and procedures (this item was a concern of Washington County Hospital).**

The panel, noting that the Washington Hospital had agreed that this had been a problem with only one HMO, stated that it was not aware that this was a systemic problem. They had no data

on the magnitude of the issue but would not be opposed to timely notification.

Due to the late hour, Senator Young asked the HMO panel to break at this point and address the other two issues at the next meeting. Those issues include: (a) utilization management guidelines; and (b) retrospective denial of reimbursement.

#### **Item IV**

Jay Schwartz, as a representative of the Health Care Provider Coalition, told the Task Force that the Coalition has a work group that is going to finalize its recommendations addressing grievance mechanisms on Tuesday, November 5 which will then go to the Coalition for approval on Friday, November 8.

Mr. Schwartz offered some general notions that should be considered. He suggested that the MIA is not the proper place to serve as the single point of entry, as the MIA gives HMOs the "home court" advantage. He also reminded the Task Force that, under the 1115 Medicaid Waiver, Medicaid enrollees will have access to an ombudsman and a grievance process. Mr. Schwartz also suggested a possible need for a uniform form for complaints much like there exists for complaints on the Property/Casualty side of insurance.

#### **Item V**

Senator Young requested, for the next meeting, the Attorney General's Health Advocate brief the Task Force. The MIA and DHMH will also comment on the case studies they have prepared. The HMOs and the provider representatives will address the two outstanding issues: (a) utilization management guidelines; and (b) retrospective denial of reimbursement.

The next meeting is scheduled for Tuesday, October 29, 1996 at 10:00 a.m. A final work session is scheduled for Tuesday, November 12, 1996 at 3:00 p.m.



GENERAL ASSEMBLY OF MARYLAND  
ANNAPOLIS, MARYLAND 21401

## **The Task Force to Study Patient and Provider Appeal and Grievance Mechanisms**

**Tuesday, October 29, 1996**

Task Force members present: Delegates Donoghue, and Hammen; Senators Young, Madden, and Astle; Eric R. Baugh, M.D.; James R. Christina, D.P.M.; Willarda V. Edwards, M.D.; Elmira C. Gwynn; Burt Allan Littman, M.D.; and R. Lane Wroth, M.D.

### **Item I**

Kevin Simpson, the Attorney General's Health Advocate, briefed the Task Force. He gave an overview of the Health Advocate's office in trying to mediate disputes for consumers. He noted that, although his office cannot order a particular remedy, there has been an 80 to 85 percent success rate in arriving at a satisfactory result for the consumer.

As to HMO complaints, most of the Office's focus is on billing issues but these issues are usually linked to other types of concerns. For example, the Office will address emergency room procedures (authorization); authorization of care (specialists); substance abuse and mental illness (disputes over level of care); issues of when a person's coverage started or ended; and certain claims issues (if it was timely, if the provider was participating, etc.). Mr. Simpson noted that some consumers that contact his office have tried to use the HMO's appeal process at some level and are not satisfied. However, there are those HMO enrollees who have not followed the appeals process through the whole way, in which case, the Office will help the patient through the internal process.

According to Mr. Simpson, many enrollees complain about the time involved for appeals and that they want the communication to be more open with specific reasons given for denials and more concise information in the response letter from the HMO. Enrollees also need to have a better understanding of the required steps of the internal appeals process.

Mr. Simpson stated that his office received approximately 75 to 80 complaints against HMOs in the past twelve months. Of the 800 to 1000 complaints the Health Advocate receives each year, HMO-related complaints account for about 10 percent. In response to a question from Dr. Littman, Mr. Simpson replied that his office does not address issues between HMOs and

providers except when a provider has brought a complaint on behalf of a patient. Any contractual issues contending that an HMO is not in compliance with state law are referred to the Maryland Insurance Administration. Mr. Simpson cited the need for better education for HMO enrollees, especially for the incoming Medicaid and Medicare populations. He also saw a need for an independent entity to represent enrollees during the complaint process.

## **Item II**

Carol Benner, Director of DHMH's Licensing and Certification Administration, Larry Triplett, Director of DHMH's Medical Care Finance and Compliance Administration, and Alex Thomas, Staff Attorney for Legislation at the Maryland Insurance Administration, provided the Task Force with some case studies that each of their offices had received. Mr. Triplett noted that Medicaid enrollees can either: (1) use the Hotline to resolve a problem; or (2) disenroll from the HMO. The MIA referred to the complaint procedures in Pennsylvania which require that an enrollee go through the HMO's internal grievance process first. All Pennsylvania HMOs must use the same grievance procedure as prescribed by law which includes the use of an outside panel for making medical decisions.

Dr. Littman brought up the issue of when a patient wants a certain treatment and the HMO says it is not a covered benefit.

Senator Young asked if a limit, either implicit or explicit, on the amount of time a physician can spend with a patient could be considered a quality of care complaint. Representatives of the HMOs replied that their consumer surveys include a question about whether an enrollee is satisfied with the amount of time that a physician is spending with the enrollee. The HMOs indicated that the satisfaction rate was quite high.

## **Item III**

Representing the HMOs, Bob Enten (MAHMO) and Kathleen Loughran (Prudential) addressed the Task Force on the issues of utilization management guidelines, and retrospective denial of reimbursement.

Mr. Enten noted that Utilization Review (UR) guidelines are not "top secret." Most Private Review Agents (PRA) use Milliman and Robertson, a copyrighted guideline of over 10,000 pages. If there is a dispute, a provider will talk with the HMO's Medical Director about UR guidelines. The UR guidelines are proprietary to the people that copyright and sell them. Dr. Littman stated that most problems arise from the ancillary guidelines that are developed by the HMOs themselves.

The HMOs recognized that retrospective denial of reimbursement is a problem but the HMOs are at the mercy of other people (employers). When employees change jobs or change health

plans there is always the potential that the information is not conveyed in an expedient fashion. Mr. Enten questioned the extent of the problem. He stated that all HMOs are trying to do a better job with patient and provider satisfaction. He noted that in all the case studies presented by DHMH and the MIA, there was no instance of arbitrary or capricious behavior; there are mistakes made but there is a continuous process to minimize mistakes. He agreed that further education is needed to educate employers about how important timely information is to the reimbursement system. Proper reimbursement is an issue for HMOs, providers, and hospitals. He noted that current law permits denial of payment if the patient is not a covered member. The provider can collect from the patient if the patient is not a covered member. Dr. Littman stated that sometimes there is a one to two year gap between the time a payment is made and the time the retrospective denial is made.

Senator Madden requested that legislative staff in consultation with interested parties find out how other states are addressing this problem before the beginning of the 1997 Session.

#### **Item IV**

Representatives of the provider community, Pegeen Townsend (Maryland Hospital Association [MHA]), Jay Schwartz (Med-Chi), and Steve Buckingham (a number of social work providers), addressed the Task Force on their views about utilization management guidelines, and retrospective denial of reimbursement.

Ms. Townsend gave a legislative history of Maryland's Utilization Review laws. She noted that the Medicaid 1115 Waiver regulations contain an outside appeals process. She also voiced several other concerns of the MHA including incidents when a physician under contract with an HMO approves a hospital admission or certain length of stay and then the HMO billing office denies reimbursement on the grounds that the admission/length of stay was not medically necessary; the denial of payment for a 23 hour hospital stay (not a full day); retrospective denials in relation to accounts receivable; undisputed claims not being paid in a timely manner; and the problems occurring between DHR's EVS computer system and DHMH's MMIS computer system for the Medicaid population. There is a need for "real time" eligibility information and she noted that a similar lack of communication between the two systems has been a big problem in other states' Medicaid Waiver programs.

Mr. Buckingham highlighted the issue of the mixed question of coverage (access) and quality and the fact the coverage issue often impacts on the quality of care. Utilization Review guidelines are supposed to provide the "rules of the game" and providers need to know the specifics on how a claim will be viewed. Without the specifics, the provider is operating in the dark and patients don't really know their benefits. A "covered service" is not always clear to patients and sometimes not even to a provider. The denial letters are not clear therefore a provider does not know if balance billing is permitted.

### **Item V**

Senator Young requested that, by November 9, the HMOs and the Provider Coalition submit proposals for the Task Force to consider. The Task Force will have a Work Session on Tuesday, November 12, 1996 at 3:00 P.M.

APPENDIX 3



GENERAL ASSEMBLY OF MARYLAND  
ANNAPOLIS, MARYLAND 21401

October 22, 1996

Honorable Thomas V. Mike Miller, Jr., President of the Senate  
Honorable Casper R. Taylor, Jr., Speaker of the House

The Task Force to Study Patient and Provider Appeal and Grievance Mechanisms respectfully requests an extension in the amount of time it has to submit its report to the Chairmen of the Senate Finance and House Economic Matters Committee as required by House Bill 1374 (1996). The legislation required a report to be submitted by October 15, 1996. In light of the amount of time required to study this issue, the Task Force requests until November 15, 1996 to submit its report.

Respectfully,

A handwritten signature in black ink, appearing to read "Larry Young".

Larry Young  
Senate Chairman

A handwritten signature in black ink, appearing to read "John P. Donoghue".

John P. Donoghue  
House Chairman

cc: Senator Thomas L. Bromwell, Chairman, Senate Finance Committee  
Delegate Michael E. Busch, Chairman, House Economic Matters Committee



APPENDIX 4  
**Maryland**  
Insurance Administration

October 4, 1996

The Honorable John P. Donoghue  
321 House Office Building  
Annapolis, Maryland 21401-1991

The Honorable Larry Young  
306 Senate Office Building  
Annapolis, Maryland 21401-191

Dear Delegate Donoghue and Senator Young:

Following up my comments to the Task Force on Patient Provider Appeals - Health Care Complaints, I am hereby submitting some information on the MIA internal Complaint Committee.

The charge of the Complaint Committee is to review and improve the complaint process with the MIA to expedite and satisfactorily resolve consumer, provider, and producer complaints. Part of the Committee's charge is also to design a relational data base that will log all complaints in a manner that will allow the MIA to extract relevant information on the number and types of complaints received.

The membership of the Committee is:

Deputy Commissioner	Charles Kelly
Director, MIS	Charles Mahon
Chief Life & Health Investigator	John Riggle
Chief Life & Health Actuary	Howard Max
Life & Health Investigator	Nat Holliday
Life & Health Investigator	Marie Lonesome
Principal Counsel	Dennis Carroll

The Committee's next meeting will take place shortly after our next Information Systems Director. Charles Mahon starts work at the MIA on October 7, 1996. After that, the scheduled is as follows:

<u>Mid-Oct</u>	Next Meeting
<u>Oct-Nov</u>	Needs analysis, review and understanding of present process
<u>Dec-Jan</u>	Design critical path for service input and delivery
<u>Feb-March</u>	Database design of critical input, processing and reporting parameters

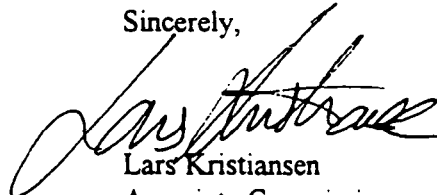


October 4, 1996  
Page Two

April-May      Programming database  
May-June      Testing Phase (program rollout with analysis)  
July            Full implementation

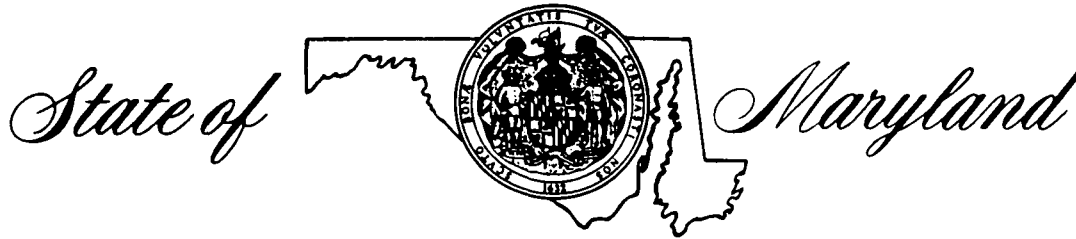
I hope this information is of use to you. If you have any further questions, please do not hesitate to contact me.

Sincerely,



Lars Kristiansen  
Associate Commissioner

cc:      Dwight K. Bartlett, Insurance Commissioner  
         Charles B. Kelly, Deputy Commissioner  
         Enrique Martinez  
         Donna Imhoff  
         Nat Holliday  
         Charles Mahon  
         John Riggle  
         Howard Max  
         Marie Lonesome  
         Dennis Carroll



**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**

4201 PATTERSON AVENUE • BALTIMORE, MARYLAND 21215-2299

Parris N. Glendening  
Governor

Martin P. Wasserman, M.D., J.D.  
Secretary

August 26, 1996

Mr. Enrique Martinez-Vidal  
Legislative Reference  
Research Division  
90 State Circle  
Annapolis MD 21401

RE: HMO Complaint Summary

Dear Mr. Martinez-Vidal:

As you recently requested, I have enclosed a summary HMO complaints received by this agency since 1990. The summary includes the frequency of complaints received during this period, and a breakdown of the category of complaints received in 1996 to date.

If you have questions regarding this information, or if you have any questions, please contact Mr. James Ralls of my staff at 410-764-4970.

Sincerely,

  
Carol Benner, Director  
Licensing & Certification Administration

Enclosure

cc: Tracey DeShields

**STATE OF MARYLAND  
DEPARTMENT OF HEALTH & MENTAL HYGIENE  
LICENSING & CERTIFICATION ADMINISTRATION**

**HMO COMPLAINT SUMMARY, 1990 TO YEAR TO DATE**

<u>YEAR</u>	<u>COMPLAINT FREQUENCY</u>
1990	12
1991	12
1992	40
1993	30
1994	20
1995	12
1996	16

The 16 complaints received this year to date can be broken down into the following categories:

<u>CATEGORY</u>	<u>FREQUENCY</u>
Access to Services	8
Quality of Care Issues	6
Benefit Coverage issues	2

## APPENDIX 6



November 8, 1996

AETNA HEALTH PLANS OF  
THE MID-ATLANTIC, INC.

BLUE CROSS AND  
BLUE SHIELD OF  
MARYLAND HMOs

CAPITALCARE

CHESAPEAKE HEALTH  
PLAN, INC.

CIGNA HEALTHCARE  
MID-ATLANTIC, INC.

GEORGE WASHINGTON  
UNIVERSITY HEALTH PLAN

NYLCARE  
HEALTH PLANS, INC.

HUMANA GROUP  
HEALTH PLAN, INC.

KAISER PERMANENTE

M.D. IPA/  
OPTIMUM CHOICE, INC.

THE PREFERRED  
HEALTH NETWORK

PRINCIPAL HEALTH CARE  
OF THE MID-ATLANTIC

PRUDENTIAL HEALTH CARE  
PLAN OF THE  
MID-ATLANTIC

TOTAL HEALTH CARE

U.S. HEALTHCARE

The Honorable Larry Young  
Senate Chairman  
Task Force to Study Patient and Provider  
Appeals and Grievance Mechanisms  
General Assembly of Maryland  
Annapolis, Maryland 21401

and

The Honorable John P. Donoghue  
House Chairman  
Task Force to Study Patient and Provider  
Appeals and Grievance Mechanisms  
General Assembly of Maryland  
Annapolis, Maryland 21401

Dear Senator Young and Delegate Donoghue:

On behalf of the Maryland Association of Health Maintenance Organizations (MAHMO), which represents 20 licensed HMOs in Maryland, serving more than 2.3 million Marylanders, please accept the following comments and recommendations concerning the work of your Task Force. As one of its goals, MAHMO seeks to increase public understanding of the managed care industry, as well as provide advocacy, education and research services to its members.

MAHMO believes that the testimony presented before your Task Force supports the conclusions reached by the HMO industry in this letter. ***MAHMO recommends that any report submitted by the Task Force should: 1) have the MLA as a single point of entry for complaints; and 2) need not call for any legislative action during the 1997 session.***

Based on the three hearings held before the Task Force, MAHMO has concluded the following:

(1) ***No documentation was presented to the Task Force which would support the supposition that the current system of appeals and grievances for patients is not working.***

(2) HMOs are subject to more consumer protection provisions than any other entity in the health care arena, including hospitals and physicians. These provisions include: (a) §19-705.1(e); (b) §19-710(l); (c) §19705.2; (d) §19-1305.2; (e) Article 48A § 490CC(g); (f) COMAR 10.07.11.11. According to the agencies which regulate the HMO industry, these provisions are working. No objective evidence to the contrary was presented by any witnesses appearing before the Task Force.

22

SERVING OVER 2 MILLION MARYLANDERS

77 WEST STREET • SUITE 210 • ANNAPOLIS, MARYLAND 21401 • BALTIMORE (410) 269-8007 • WASHINGTON (301) 858-5551 • FAX (410) 269-1216

The Honorable Larry Young and John P. Donoghue  
Task Force to Study Patient and Provider Appeal  
and Grievance Mechanisms

November 8, 1996

Page 2

(3) Both state agencies that regulate HMOs in Maryland, the Department of Health and Mental Hygiene (DHMH) and the Maryland Insurance Administration (MIA), have consistently stated that the number of complaints against HMOs are few and far between. DHMH has received 16 over the past year, Medicaid has received 150, and the MIA has received a very small amount. ***MAHMO SUBMITS THAT THIS TESTIMONY REVEALS THE SERIOUS MANNER IN WHICH HMOs DEAL WITH APPEALS AND GRIEVANCES BY MEMBERS AND IS FURTHER EVIDENCE OF THE QUALITY HEALTH CARE PROVIDED BY HMOs IN MARYLAND.***

(4) In an independent report by Families USA Foundation, Maryland was among four states cited for providing the most extensive application and termination protections to providers in the country.

(5) MAHMO presented testimony from Total Health Care, Chesapeake Health Plan, and BCBSM on the use and effectiveness of the patient and provider appeal and grievance mechanisms currently in law.

(6) Based on the language and intent of the legislation governing this Task Force, issues related to notification, utilization management guidelines, and retrospective denial of reimbursement are not within the scope of this Task Force's charge and should not be addressed in any report submitted to the House Economic Matters Committee or Senate Finance Committee. Notwithstanding the scope of the Task Force's charge, problems with notification do not appear to be wide spread; utilization management guidelines are generally available; and the issue of retrospective denial needs to be addressed by greater cooperation between all interested parties.

**MAHMO RECOMMENDATIONS TO THE TASK FORCE**

With these thoughts in mind, MAHMO makes the following recommendations to the Task Force on Patient and Provider Appeal and Grievance Mechanisms:

(1) In order to improve the use and effectiveness of current appeal mechanisms with the DHMH and MIA, the ***Task Force should recommend that the MIA be the single point of entry for all appeals and complaints regarding HMOs; and***

(2) After examining the evidence and testimony presented to the Task Force, ***NO LEGISLATIVE ACTION IS REQUIRED FOR THE 1997 SESSION CONCERNING THE ISSUE OF PLAN APPEAL MECHANISMS.***

MAHMO reached these recommendations after considering the testimony presented by various State agencies and interested parties at the following hearings as summarized below.

The Honorable Larry Young and John P. Donoghue  
Task Force to Study Patient and Provider Appeal  
and Grievance Mechanisms  
November 8, 1996  
Page 3

#### OCTOBER 1, 1996 TASK FORCE HEARING

As you know, representatives from the MIA and DHMH made a presentation of current departmental policy concerning appeals and grievances. *Representatives of the MIA stated at this hearing that of the complaints received by MIA, none have gone beyond the initial inquiry level. Furthermore, very rarely does a complaint not get handled within 30 days.* Currently, the MIA is in the process of reviewing and upgrading an antiquated computerized complaint system. MAHMO would agree with several members of the Task Force, including the Senate Chairman, that this system needs to be re-examined and upgraded. MAHMO supports the work currently being performed by the Insurance Commissioner on improving this system in order to make it more consumer and industry friendly. The MIA outlined its process for reviewing complaints and indicated that these processes are checked during a market conduct examination. Records from the HMO are checked against those of the MIA. Penalties may be levied against an HMO during a market conduct examination for violations of the law pertaining to appeals and grievances procedures.

#### OCTOBER 22, 1996 HEARING

At this hearing, Carol Benner and Larry Triplet each discussed appeal and grievance mechanisms within DHMH. Ms. Benner talked about the role of Licensing and Certification and Mr. Triplet talked about the Medicaid Department's process. Ms. Benner gave an overview and history of the current regulations on HMOs with respect to appeals and grievances. *She indicated that the number of grievances received by her office during the past year was extremely small. She indicated that it was probably less than 50.* This, despite the fact that HMOs are required to have the phone number of Licensing and Certification on all membership material. Ms. Benner further stated that during several visits to HMOs last year, *she was very satisfied with how HMOs document and handle complaints and grievances and that, in fact, they do a "very good job."*

Mr. Triplet spoke at length about protections in the current Medicaid program for HMO Medicaid members to appeal decisions and render complaints. The current program has a Medicaid "hotline" which received about 6,000 inquiries last year. *Mr. Triplet indicated that the vast majority of these were for information and only 150 were documented complaints or grievances.* Mr. Triplet indicated that under the new Medicaid program, Medicaid recipients will have an appeals and grievance mechanism.

Following the testimony of the representatives of DHMH, interested parties were asked to comment on four specific items of interest to the Task Force. *MAHMO reiterates its support for a single point of entry for complaints.* Currently, both DHMH and MIA receive complaints from consumers. A single point of entry for complaints would make the process easier for consumers and the industry. Because HMOs are licensed and primarily regulated by MIA,

Task Force to Study Patient and Provider Appeal  
and Grievance Mechanisms

November 8, 1996

Page 4

MAHMO believes MIA is in the best position to fill this role. A second issue discussed was timely notification to providers of new or changed utilization review policies and procedures. It is MAHMO's understanding that this problem occurred between one hospital and one HMO, and that the problem was being addressed by the HMO. MAHMO further reiterated its position that both utilization management guidelines and retrospective denial of reimbursement were beyond the scope and charge of the Task Force.

**OCTOBER 29, 1996 HEARING**

In an effort to obtain as much information as possible on this subject, the Task Force requested the Attorney General's (AG) Health Advocate, Kevin Simpson, to present testimony at this hearing. Mr. Simpson reviewed how the AG's office handles consumer complaints from HMOs and providers. *During the past year, the Health Advocate has received only 75-80 complaints from HMO members. He also indicated that his office receives many more complaints against physicians.* Mr. Simpson indicated that there probably is a need for more information and education on how to appeal decisions of HMOs and providers and more education regarding the hold harmless protection in the law. Mr. Simpson testified that in roughly 85 percent of all negotiated settlements, his office was able to resolve the dispute between the subscriber and the HMO.

In response to a request from the Task Force, DHMH and MIA presented several case studies of appeals and grievances filed by HMO members over the past year. Of the six case studies presented by DHMH, five were concluded to have no evidence of quality of care issues. *Ms. Benner also indicated that she checked the number of complaints within the last year, and her office has received only 16 complaints regarding quality of care. The MIA also presented case studies which indicated that virtually all complaints were handled within 30 days, that HMOs were in compliance with State law, and that none went beyond the initial complaint stage.*

MAHMO further reiterated its position that both utilization management guidelines and retrospective denial of reimbursement were beyond the scope and charge of the Task Force. With respect to utilization management guidelines, it is MAHMO's understanding that this information is provided to and filed with the MIA. Furthermore, this information is copyrighted by particular groups and HMOs are forbidden by copyright laws to make copies available. Descriptions of the criteria can be distributed to physicians by plans or physicians can purchase copies of this utilization management information.

Lastly, MAHMO understands the position of the physician community with respect to retrospective denials of reimbursement. MAHMO concurs with the physician community that we should know who is and is not a member of a plan. However, HMOs are caught in the same net as physicians. On the public sector side, HMOs in Medicaid must rely on the State to inform HMOs in a timely fashion of Medicaid recipients who enroll and disenroll in HMOs. MAHMO



The Honorable Larry Young and John P. Donoghue  
Task Force to Study Patient and Provider Appeal  
and Grievance Mechanisms

November 8, 1996

Page 5

has presented testimony before the Senate Budget and Taxation Committee and Senate Finance Committee regarding concerns the industry has with the State's computer system. On the private sector side, HMOs rely on employers to make timely notification of changes in employee coverage. HMOs currently have language in their contracts for this notification, however, enforcement of this is quite difficult.

If you have any further questions, please do not hesitate to contact me at the Association.

Sincerely,



Martha C. Roach  
Executive Director

cc: The Honorable Michael E. Busch, Chairman, Economic Matters Committee  
The Honorable Thomas L. Bromwell, Chairman, Finance Committee  
The Honorable Casper R. Taylor, Jr., Speaker, House of Delegates  
The Honorable Thomas V. "Mike" Miller, Jr., Senate President  
Randi Reichel, Associate Commissioner, Life & Health, MIA  
Carol Benner, Director, Licensing & Certification, DHMH  
D. Robert Enten, Esquire

## APPENDIX 7

LAW OFFICES

JOSEPH A. SCHWARTZ, III, P.A.

10 WEST MADISON STREET

BALTIMORE, MARYLAND 21201

3 CHURCH CIRCLE

ANNAPOLIS, MARYLAND 21401

ANNAPOLIS

TELEPHONE: 410-269-1618

FACSIMILE: 410-369-5443

BALTIMORE

TELEPHONE: 410-244-7000

FACSIMILE: 410-332-4505

JOSEPH A. SCHWARTZ, III

---

### FACSIMILE MEMORANDUM

---

TO: The Honorable Larry Young, Senate Chairman  
The Honorable John P. Donoghue, House Chairman  
Patient and Provider Appeals and Grievance Task Force

FROM: Joseph A. Schwartz, III

DATE: November 8, 1996

RE: Proposal for Unified Appeal and Grievance System

---

Attached is the Proposal for Unified Appeal /Grievance System prepared and endorsed by the Health Care Provider Coalition. The Coalition had meetings and discussions with the Health Advocacy Unit of the Attorney General's office and discussions with the Office of Administrative Hearings (OAH).

We realize that there may be fiscal implications to this proposal although we believe most of these to be fiscal allocation issues as the present system with its attendant costs will be replaced.

Please note that several items (Item 4, part of 5, 6) are modeled on the Maryland system since the mid-1970's for handling automobile insurance underwriting and premium surcharge decisions. While certain aspects of this system have been criticized as anti-consumer, many aspects are accepted and valuable.

We thank the Task Force for its consideration of this proposal.

JAS/jld  
jas\medchi\faxmem13.jas  
Attachment

## PROPOSAL FOR UNIFIED APPEAL / GRIEVANCE SYSTEM

The Coalition Workgroup has met on two occasions and proposes the following appeal/grievance procedure for patient and provider complaints.

1. The grievance process will cover patient/provider complaints concerning medical insurance coverage, determinations of medical necessity and also include complaints by providers concerning illegal exclusion/terminations from provider panels.
2. A patient/provider shall initially register the complaint with the carrier for decision.
3. Any "adverse decision" of the carrier shall be appealable upon the earliest of the following events:
  - a. an adverse decision by the carrier's internal grievance process or utilization review process, or
  - b. thirty days from the filing of the initial complaint by the patient/provider if no carrier decision, or
  - c. such shorter time period for decision as may be provided by a present statute governing utilization review.
4. The "adverse decision" shall be in writing and shall contain the specific factual bases and criteria relied upon as a basis for the decision. Generalized phrases such as "cosmetic procedure not covered," "not medically necessary," or "experimental procedure" shall not be sufficient.
5. Carrier — in rendering an adverse decision in writing — shall provide the patient and/or provider with a uniform appeals form which shall advise the patient/provider of his or her right to seek (a) mediation at the Health Advocacy Unit of the Attorney General's office or (b) an adjudicatory hearing at the Office of Administrative Hearings (OAH). The form shall give the addresses and phone numbers of these agencies and serve as the intake form concerning such appeals. The form should encourage mediation before the Health Advocacy Unit of the Attorney General's office as a first step (mediation would not be required but strongly encouraged and would "toll" time deadlines for a formal appeal). This uniform form would be similar to form mandated for automobile insurers by 48A Md. Code Ann. § 240AA.
6. The carrier shall have the "burden of persuasion" that its decision is correct. This replicates requirement placed on automobile and property and casualty insurers in 48A Md. Code Ann. § 234 A. 240C.
7. All carriers shall provide a description of their internal grievance process as well as their grievance contact person with the Health Advocacy Unit of the Attorney General's office.

8. Provider complaints relating to legal or illegal exclusion from panels shall be governed by the same procedure except that mediation shall not be a step and the appeal shall be filed directly with OAH. (Not within present scope of Health Advocacy Unit of A.G.'s office)
9. MIA and DHMH shall delegate its hearing jurisdiction over these matters — to the extent not already done — to OAH.
10. The normal rules and OAH hearings shall apply including rights and rules of judicial review.
11. Health Advocacy Unit of A.G.'s office would file Annual Report outlining claims made and disposition.

jas\medchi\appeal

PARRIS N. GLENDENING  
Governor

# Maryland

## Insurance Administration

DWIGHT K. BARTLETT, III  
Insurance Commissioner

November 23, 1996

Honorable Larry Young  
306 James Senate Office Building  
Annapolis, Maryland 21401

Honorable John P. Donoghue  
321 Lowe House Office Building  
Annapolis, Maryland 21401

Re: Task Force on Patient/Provider Complaints

Dear Senator Young and Delegate Donoghue:

This letter is the Maryland Insurance Administration's response to the November 8th proposal by MedChi for a "Unified Appeal and Grievance System" ("The Proposal"). The Insurance Administration has also reviewed the recommendations from the Maryland Association of Health Maintenance Organizations.

The Proposal requires that patient or provider complaints against health maintenance organizations ("HMOs") be handled through a carrier's internal grievance system. Unsatisfied providers or patients may then avail themselves of arbitration mediated by the Attorney General's Health Advocacy Office ("AG's Office") and from there, may progress to the Office of Administrative Hearings ("OAH"). Under the Proposal, complainants may also bypass the AG's Office and go directly to OAH. The MIA believes that this proposal is not in the best interests of Maryland's citizens, and is not designed to be efficient or effective.

The system described in the proposal is inefficient and cumbersome

The Maryland Insurance Administration receives approximately 4000 life and health inquiries and complaints annually. Almost half of these are health related complaints and inquiries. The vast majority of these complaints are resolved, with no appeal, within 30 days. This would not be possible under the MedChi proposal. The representative from the Attorney General's Office testified at the October 29, 1996 Task Force meeting that his office only receives 75-80 complaints per year, and that mediation on any given complaint could take up to 6 months. Although mediation is, in the right circumstances, appropriate and beneficial, it is not so in this case. Given the volume handled by the Insurance Administration, the mediation time-frame is unacceptable.

Expedience is no better at the Office of Administrative Hearings. The hearings at OAH are governed by State Government Article, §10-201 et seq., the Annotated Code of Maryland, The Administrative Procedure Act ("APA"). Under the APA, notice of a hearing must be issued thirty days before the hearing, postponements are the rule rather than the exception, and a final decision can take up to 90 days after the hearing. Of course, because of the adversarial nature of the OAH procedures, appeals are to be expected, which would encourage a further delay to the citizen seeing claims' payments. Based on expedience alone, the MedChi proposal takes a step backwards by abolishing the current 30 day procedure, and recommending a procedure which has no time limit at the AG's Office, and which would take a minimum of 120 days at the OAH.

### The MedChi proposal contains no finality

The AG's Office, under current practice, and pursuant to the proposal, acts as mediator only. By contrast, the Insurance Administration, as the licensing authority, may, and does, issue orders to companies requiring certain actions. A company's refusal to comply may result in fines, penalties, or suspension or revocation of its license. But in no event does this require a consumer to expend further monies or take further actions. By contrast, unsuccessful mediation will put the consumer in the position of having to take further action, possibly hire counsel, and appeal to OAH. This will add cost, time and discover to the consumer's responsibility. This is unnecessary.

Neither is OAH the appropriate forum for this type of complaint. The OAH functions primarily after an agency decision has been rendered. In the cases in which the Insurance Administration delegates to the OAH its hearing jurisdiction, the OAH is rendering a proposed decision; the Insurance Administration still renders a final decision. The purpose behind this is the preservation of consistency in the Insurance Administration's regulation of the industry. The Insurance Administration reviews the proposed decision to ensure that the proposal comports with the Insurance Code, and with current administrative and market practices. The Insurance Administration also ensures that penalties and restitution are applied consistently. This is the appropriate function of a regulatory agency. Without Insurance Administration oversight the regulatory environment would be bifurcated and chaotic.

The Proposal does not clarify what the citizen would need to file with the OAH. Currently, each contested case before the OAH has some form of a statement of the issues such as agency charges, or an agency preliminary decision. A letter simply alleging a complaint such as "failure to pay claims" before the OAH would be insufficient, because the OAH has no investigatory powers. The Insurance Administration does. In addition, the OAH hearing procedure does not encompass formal pleadings or discovery. Therefore, The Proposal seeks to assign a matter to OAH without a preliminary fact-finding. Permitting the Insurance Administration to fully investigate a complaint prior to filing with OAH serves a dual function. It permits the state agency responsible for industry oversight to undertake the fact finding, rather than shifting this burden to the consumer; and it permits the OAH to review a complete record, in those contested cases which come before it, rather than to be forced to opine on an incomplete record.

### The MedChi proposal does not address medical necessity

MedChi has alleged on a number of occasions that the current complaint system is flawed, primarily because there is no mechanism for handling issues regarding medical necessity. However, this proposal offers no solution to handling medical necessity complaints. The proposal does not address how medical necessity issues will be resolved at the AG's Office or at OAH; these two bodies would face the same problem which the Insurance Administration faces; they have no medical expertise and there is no existing panel of doctors to review these types of cases.

### The Maryland Association of Health Maintenance Organizations Proposal

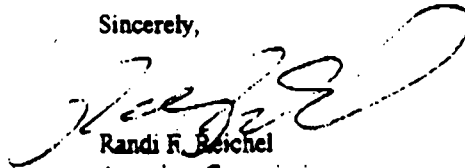
The Insurance Administration supports Recommendation Number 1 made by the Maryland Association of Health Maintenance Organizations ("MAHMO") dated November 8, 1996, which recommends that the Insurance Administration be the single point of entry for all HMO appeals and complaints. The Patient Access Act requires policies to indicate the Insurance Administration as the agency responsible for hearing complaints, the MHA telephone number and the process for filing a complaint at the MJA. Last year, the Insurance Administration received approximately 4,000 life and health inquiries or complaints, the AG's Office received approximately 80, and the Department of Health and Mental Hygiene received 16 complaints. Clearly, complainants already regard the Insurance Administration as the primary agency with which to file a complaint.

The Maryland Insurance Administration Internal Complaint Review Committee is critically studying the complaint process. The Insurance Administration has spent several weeks and considerable time in manually reviewing the complaints and inquiries to segregate the complaints by issues and outcomes. This report should be completed shortly. Preliminary outcomes should be released within the next two weeks. The Insurance Administration suggests that this data will dispel any anecdotal allegations that the current process for handling

consumer complaints is seriously flawed. Further, it is anticipated that the antiquated computer will be replaced in June, and that the Administration will be able to compile this type of data on an ongoing basis. The Committee is also considering standardization of forms.

Please do not hesitate to contact me with questions or concerns.

Sincerely,

A handwritten signature in dark ink, appearing to read "Randi F. Reichel", with a large, sweeping flourish extending to the right.

Randi F. Reichel  
Associate Commissioner  
Life and Health

cc: Dwight K. Bartlett, III, Insurance Commissioner  
Lars Kristiansen, Associate Commissioner for Policy  
Alexandra Thomas, Staff Attorney